PREVAILED	Roll Call No. _____
FAILED	Ayes _____
WITHDRAWN	Noes _____
RULED OUT OF ORDER	

HOUSE MOTION ____

MR. SPEAKER:

I move that Engrossed Senate Bill 164 be amended to read as follows:

Page 2, after line 4, begin a new paragraph and insert:

"SECTION 3. IC 12-15-44.2-4, AS ADDED BY HEA 1137-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 4. (a) The plan must include the following in a manner and to the extent determined by the office:

(1) Mental health care services.
(2) Inpatient hospital services.
(3) Prescription drug coverage.
(4) Emergency room services.
(5) Physician office services.
(6) Diagnostic services.
(7) Outpatient services, including therapy services.
(8) Comprehensive disease management.
(9) Home health services, including case management.
(10) Urgent care center services.
(11) Preventative care services.
(12) Family planning services:
(A) including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law (42 U.S.C. 1396 et seq.); and
(B) not including abortion or abortifacients.
(13) Hospice services.
(14) Substance abuse services.

~~(b) The plan must do the following:~~

~~(1) Offer coverage for dental and vision services to an individual who participates in the plan.~~

~~(2) Pay at least fifty percent (50%) of the premium cost of dental and vision services coverage described in subdivision (1).~~

~~(c) An individual who receives the dental or vision coverage offered under subsection (b) shall pay an amount determined by the office for the coverage. The office shall limit the payment to not more than five percent (5%) of the individual's annual household income. The payment required under this subsection is in addition to the payment required under section 11(b)(2) of this chapter for coverage under the plan.~~

~~(d) Vision services offered by the plan must include services provided by an optometrist.~~

~~(e)~~ **(b)** The plan must comply with any coverage requirements that apply to an accident and sickness insurance policy issued in Indiana.

~~(f)~~ **(c)** The plan may not permit treatment limitations or financial requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

SECTION 4. IC 12-15-44.2-9, AS ADDED BY HEA 1137-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 9. (a) An individual is eligible for participation in the plan if the individual meets the following requirements:

(1) The individual is at least eighteen (18) years of age and less than sixty-five (65) years of age.

(2) The individual is a United States citizen **or a qualified alien (as defined in 8 U.S.C. 1641(b))** and has been a resident of Indiana for at least twelve (12) months.

(3) The individual has an annual household income of not more than two hundred percent (200%) of the federal income poverty level.

(4) The individual is not eligible for health insurance coverage through the individual's employer.

(5) The individual has not had health insurance coverage for at least six (6) months.

(b) The following individuals are not eligible for the plan:

(1) An individual who participates in the federal Medicare program (42 U.S.C. 1395 et seq.).

(2) A pregnant woman for purposes of pregnancy related services.

(3) An individual who is eligible for the Medicaid program as a disabled person.

(c) The eligibility requirements specified in subsection (a) are subject to approval for federal financial participation by the United States Department of Health and Human Services.

SECTION 5. IC 12-15-44.2-11, AS ADDED BY HEA 1137-2008,

SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 11. (a) An individual's participation in the plan does not begin until an initial payment is made for the individual's participation in the plan. A required payment to the plan for the individual's participation may not exceed one-twelfth (1/12) of the annual payment required under subsection (b).

(b) To participate in the plan, an individual shall do the following:

(1) Apply for the plan on a form prescribed by the office. The office may develop and allow a joint application for a household.

(2) If the individual is approved by the office to participate in the plan, contribute to the individual's health care account the lesser of the following:

(A) One thousand one hundred dollars ($1,100) per year, less any amounts paid by the individual under the:

(i) Medicaid program under IC 12-15;

(ii) children's health insurance program under IC 12-17.6; and

(iii) Medicare program (42 U.S.C. 1395 et seq.);

as determined by the office.

(B) Not more than the following applicable percentage of the individual's annual household income per year, less any amounts paid by the individual under the Medicaid program under IC 12-15, the children's health insurance program under IC 12-17.6, and the Medicare program (42 U.S.C. 1395 et seq.) as determined by the office:

(i) Two percent (2%) of the individual's annual household income per year if the individual has an annual household income of not more than one hundred percent (100%) of the federal income poverty level.

(ii) Three percent (3%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred percent (100%) and not more than one hundred twenty-five percent (125%) of the federal income poverty level.

(iii) Four percent (4%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred twenty-five percent (125%) and not more than one hundred fifty percent (150%) of the federal income poverty level.

(iv) ~~Five~~ **Four and five-tenths** percent ~~(5%)~~ **(4.5%)** of the individual's annual household income per year if the individual has an annual household income of more than one hundred fifty percent (150%) and not more than two hundred percent (200%) of the federal income poverty level.

(c) The state shall contribute the difference to the individual's account if the individual's payment required under subsection (b)(2) is

less than one thousand one hundred dollars ($1,100).

(d) If an individual's required payment to the plan is not made within sixty (60) days after the required payment date, the individual may be terminated from participation in the plan. The individual must receive written notice before the individual is terminated from the plan.

(e) After termination from the plan under subsection (d), the individual may not reapply to participate in the plan for twelve (12) months.

SECTION 6. IC 12-15-44.2-14, AS ADDED BY HEA 1137-2008, SECTION 98, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 14. (a) An insurer or health maintenance organization that contracts with the office to provide health insurance coverage ~~dental coverage, or vision coverage~~ to an individual that participates in the plan:

(1) is responsible for the claim processing for the coverage;

(2) shall reimburse providers at a reimbursement rate of:

(A) not less than the federal Medicare reimbursement rate for the service provided; or

(B) at a rate of one hundred thirty percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate; and

(3) may not deny coverage to an eligible individual who has been approved by the office to participate in the plan, unless the individual has met the coverage limitations described in section 6 of this chapter.

(b) An insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan must incorporate cultural competency standards established by the office. The standards must include standards for nonEnglish speaking, minority, and disabled populations.".

Renumber all SECTIONS consecutively.

(Reference is to ESB 164 as printed February 8, 2008.)

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Representative Brown C